PRINTED: 05/16/2011 FORM APPROVED -0391

ETAKTMENT OF HEALTHAND HOM	TORMATIKO			
CENTERS FOR MEDICARE & MEDICA	AID SERVICES			OMB NO. 0938-
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		P. WING		04/06/2011

NAME OF PROVIDER OR SUPPLIER

2288 NICHOLAS CT

SHIELD	S HOUSE		8 NICHOLAS CT YMOUR, IN47274		
(X4) ID PREFIX	PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
TAG R0000	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
100000	This visit was for a State Licensure Survey. Survey dates: April 5, 6, 2011 Facility number: 004376 Provider number: 004376 AIM number: N/A Survey team: Amy Wininger, RN TC Melinda Lewis, RN Marla Potts, RN Sharon Whiteman, RN (April 5, 2011) Census bed type: Residential: 31 Total: 31 Census payor type: Other: 31 Total: 31 Sample: 07 The state findings are cited in accordance with 410 IAC 16.2-5 in regard to the Residential State Licensure Survey. Quality review completed on April 8, 2011 by Bev Faulkner, RN	R0000	Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

004376

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(x3) date survey completed 04/06/2011	
NAME OF F	PROVIDER OR SUPPLIER		2288 N	ADDRESS, CITY, STATE, ZIP CODE IICHOLAS CT DUR, IN47274	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
R0006	resident: (1) is a danger to to (2) requires twenty comprehensive nut comprehensive nut (3) requires less the per day comprehe comprehensive nut rehabilitative there into a contract with provider of the resident (4) is not medically (5) meets at least three (3) criteria un medically stable a meet the resident (A) Requires total (B) Requires total (C) Requires total transferring. Based on obset and record reversided to ensure required 24 hocomprehensive required total at toileting and transferring and transferring total toileting and transferring and transferri	rising oversight; nan twenty-four (24) hour nsive nursing care, rising oversight, or ripies and has not entered n an appropriately licensed ident's choice to provide y stable; or two (2) of the following nless the resident is nd the health facility can 's needs: assistance with eating. assistance with rvation, interview iew, the facility e a resident who	R0006	Citation #1 R 006 410 IAC 16.2-5-0 (f) (1-5) Scope of Residential Care What corrective action(s) will be accomplished for those residents found to have be affected by this deficient practice? No residents were found to be affected. Resider #11 and resident #2 was re-assessed and determined be appropriate for our residentially licensed facility. Resident #11 has a third part provider implemented in collaboration with Shields Hoto ensure the licensed and unlicensed needs of this residents.	nt to ty puse

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 6JW011 Facility ID:

004376

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	1			JRVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	
			B. WIN	G		04/06/20	11
NAME OF	PROVIDER OR SUPPLIEI	3	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				1	CHOLAS CT		
SHIELD	S HOUSE			SEYMO	OUR, IN47274		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	(Resident 11)	and failed to ensure a			are met. Resident #11's wou currently showing improvement		
	resident who	refused to follow the			and is reviewed by the Welln		
	smoking polic	y was discharged due			Director weekly. Resident #2		
		self and others in			re-assessed utilizing a smok	- 1	
					assessment and was determ		
		dent #2) for 2 of 7			to need assistance from staf regarding providing cigarette		
	residents revie	ewed for meeting the			and smoking paraphernalia		
	requirements	for residential care in			request of the resident for		
	the sample of	7.			monitoring purposes. The		
					Residence has removed		
	Findings include:				cigarettes and smoking paraphernalia and will provide	le to	
					the resident upon request un		
					staff supervision. Resident #		
	1. Resident #1	1 was identified by			was educated by the Region	al	
	the Wellness I	Director on the initial			Director of Quality and Care	. 1	
		fility on 4/5/11 at 9:30			Management to our policy ar that future noncompliance w		
		•			plan will result in issuance of		
	1	dependent on staff			notice of involuntary discharg		
	for care and n	ot interviewable.			Resident #2 understands in		
	Resident #11	was observed from			event a notice of involuntary		
	9.30 a m thro	ugh 12:30 p.m. to be			discharge is issued we will provide ample notice and as	ciet	
		-			with alternative placement. F		
		gh back wheelchair in			the facility will identify other		
	the dining roo	m. A Foley catheter			residents having the potent		
	drainage bag	was observed hanging			to be affected by the same		
	beneath the ch	nair. At 1:30 p.m., a			deficient practice and what		
		urse was observed			corrective action will be take No other residents were four		
		dressing to the			be affected. All third party	10 10	
	1 0	•			providers will be in-serviced	for	
		heel. The area was			coordination of care within		
	observed to co	over the entire heel,			Shield's House. Wellness Di	rector	
	with a open w	ound, red base in the			and Resident Director will		
	center, loose y				reassess all residents upon change of condition and/or e	verv	
	1				6 months.All new residents t	-	
	surrounding ti	ne open area, with the			are smokers will have a smo	king	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
			B. WING		04/06/2011
NAME OF I	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	KOVIDER OR SUPPLIER		2288 NI	ICHOLAS CT	
	HOUSE			DUR, IN47274	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	TAG	assessment upon admission	DATE
		the yellow a deep		after 30 days, and then every	•
	dark red. The	home health nurse		months unless change of	, -
	indicated the r	esident had returned		condition. Each existing and	new
	from a hospita	1 stay on 3/28/11 with		resident smokers will be	
	_	heel. She further		educated by Residence Dire and Wellness Director to ALC	
				policy and any future	^
		hought the heel was a		noncompliance will result in	
		re ulcer and physical		involuntary discharge, we wi	ıl e
	therapy was de	ebriding it. The home		provide ample notice and assistance for alternate	
	health nurse in	dicated home health		placement. What measures	will
	provided all tro	eatments for the		be put into place or what	
	ulcer.			systemic changes will the	
	uicci.			facility make to ensure that	.
				deficient practice does not	.
	Resident #11 v	was observed at 2:20		recur? The Wellness Director and staff were re-educated to	
	P.M., on 4/5/1	1 to be transferred to		policy and procedure regardi	
	bed from the w	wheelchair by QMA		our residency agreement	
		dication Aide] #1 and		referencing our "smoke free"	• • • • • • • • • • • • • • • • • • •
		d Nursing Assistant]		facility as well as our Assiste Living Decision Tree as to	a
	=	_		reporting of such instances.	The
		members lifted the		Wellness Director and Resid	I
	resident by put	tting their arms under		Director were also re-educat	ed to
	hers and totally	y lifting her into the		their role in educating our resident population that failu	ro to
	bed. The resid	lent did not bear		comply with our smoking pol	
	weight. The re			will result in termination of th	·
	_	he bed with a pillow		lease if an alternative plan o	• • • • • • • • • • • • • • • • • • •
	•	•		agreement cannot be reach	• • • • • • • • • • • • • • • • • • •
		eet, allowing her left		ensure further compliance. will the corrective action(s)	I
	_	on the pillow. The		be monitored to ensure the	• • • • • • • • • • • • • • • • • • •
	resident's urine	e appeared a very		deficient practice will not re	
	dark tea color	and appeared		i.e., what quality assurance	
	concentrated.	1.1		program will be put into pla	I
	Concontiated.			For the next three months th Wellness Director or designe	
				**Cililoss Director of designe	,C VVIII

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
NAME OF I	PROVIDER OR SUPPLIER S HOUSE SUMMARY S (EACH DEFICIEN REGULATORY OR		A. BUI B. WIN	STREET A 2288 NI	DDRESS, CITY, STATE, ZIP CODE CHOLAS CT UR, IN47274 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEPICIENCY) perform a random weekly re	04/06/2011 (X5) COMPLETI DATE	ION
	reviewed on 4 The most rece Negotiated Se dated 11/18/10 assist during b weekly," require with showerin bathroom inde protective und staff to empty bag, staff to as empty bag ever walker and ma mobility, resid escort to area and meal frequire nervous of not way, requires personnel or th mechanical lift must assist ho changing catho keep resident of services-home outside provide	nt Assessment and rvice Plan Summary, 0, indicated "staff to athing twice tres physical assist g, unable to use the ependently, uses ergarments, needs catheter drainage esist with catheter. The staff to for exercise, activities and wheelchair for dent requires staff to for exercise, activities and assistance of two he use of a for transfers, staff me health with eter to attempt to calm, special health or other er, resident becomes es and may need to			of resident's who smoke to ensure compliance with our smoking policy and procedur Resident's will be assessed utilizing our smoking assess upon admission and as need non compliance is suspected Residents who are found to non compliant will be re-eduwith a plan to minimize risk future occurrence. In the every the plan is evaluated and four unsuccessful arrangements be made for alternative placement for that individual Findings will be reviewed with the next three months as to frequency of continued monitoring. Findings sugges of compliance will meet the criteria for cessation of our weekly review. Resident's wireviewed ongoing upon admission and as needed ar corrected through the facility process. By what date will the systemic changes be completed? Compliance Date May 15, 2011	ment ed if l. pe cated pr nt nd will hin he tive Il be d s QA he	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED					
			A. BUIL B. WINC			04/06/2	011
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
SHIELDS	S HOUSE				CHOLAS CT DUR, IN47274		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		'	ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ГЕ	COMPLETION DATE
	A nursing con	nprehensive					
	evaluation, da	ated 3/24/11, indicated					
	the resident ha	ad returned from a					
	hospital stay v	with a 7 cm					
	[centimeter] le	eft heel blister					
	yellowish, clo	sed. The evaluation					
	indicated hom	ne health notified of					
		esident lethargic and					
	only opens her eyes when she is						
	stimulated"						
	A home healtl	h note, dated 3/29/11,					
		sent tohospital on					
		ame back 3/28/11. Pt					
		to ER [emergency					
		to increased agitation					
	_	thome health care					
	was unaware	pt had been admitted					
	to hospital cal	lled and received					
	orders to see p	ot today and anchor					
	Foley catheter	rthis was removed at					
	hospital obtain	ned 600 ml yellow					
	urine without	difficultyassessed					
		er, it has opened and					
		rate amount serous					
	_	sured 6.0 cm by 7 cm					
	1	padded with gauze					
		vith Coban [a product					
	to secure dres	sings]will call Dr					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO.	NSTRUCTION 00	COMPL	
1111212111			LDING		04/06/2	
		B. WIN		DDRESS, CITY, STATE, ZIP CODE	1	
NAME OF F	PROVIDER OR SUPPLIER			CHOLAS CT		
SHIELDS	HOUSE		SEYMO	OUR, IN47274		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	,	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FUL REGULATORY OR LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETION DATE
	for wound care orders" Home	,				
	health notes, dated 3/29/11,					
	indicated "Pt was hospitalized for					
	exacerbation of Alzheimer's and					
	was released before home health					
	was notifiednow has decreased					
	self care abilitywith large open					
	blister on left heelPhysical					
	therapy for evaluation with wound					
	care." Notes, dated 3/30/11,					
	indicated physical therapy would					
	see the resident one time weekly for	or				
	six weeks for management of left					
	heel wound to include sharp					
	abridgement as indicated, dressing					
	changes as per orders, cleanse left					
	heel with normal saline, apply					
	Allevyn foam and calcium alginate	l l				
	secure with Kerlix and tape. Asses	SS				
	wound: pressure ulcer left					
	posterior heel, unstageable,					
	suspected deep tissue injury, .79 in					
	length and .98 in width, small					
	amount exudate, tissue bed-pink,					
	red, dark red.					
	The Coulting Lords 1					
	The facility lacked any					
	documentation of what the pressure	e				
	area looked like between 3/28/11					

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LDING	00	COMPL 04/06/2	ETED
	PROVIDER OR SUPPLIEI	<u> </u>	F	STREET A	DDRESS, CITY, STATE, ZIP CODE CHOLAS CT DUR, IN47274	ı	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	and when assess on 3/29/11, or implemented. any service plus pressure ulcer During intervitory. Director on 4/indicated she Facility Admit updates on the in but those concentration of the following: "7/13/11 staff to empty cather floor next to be head toward or turned over in (emergency managed assisted up" "9/2/10 6:30 properties back to facility to the facility and the service of the following in the floor next to be head toward or turned over in the facility assisted up"	essed by home health any interventions The facility lacked an to treat the ew with the Wellness 5/11 at 11:45 A.M., had gave the Health nistrator some esservice plans to type buld not be located. ice Notes indicated entered resident room eter, resident was on red feet toward bed loset, chair was from of her, EMS redical services) was necked her over and o.m. res found on floor to hospitalsent by 9 p.m. assisted to CNA and helped get					

	OF CORRECTION	IX1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING B. WING	00	li i	PLETED 2011
	PROVIDER OR SUPPLIER		2288 N	ADDRESS, CITY, STATE, ZIP CO IICHOLAS CT DUR, IN47274	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	from dining ro "10/7/10 11:30 and found res of bed crying shakingdispa- call (hospital). her she has a base of the she has a	atched 9113 A.Mthey will be keeping broken left hip" p.m. spoke ge plannerrequested ed and wheelchair brable fracture of left 10/10/10 at 7 p.m., resident had a he hip causing severe eture and had				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED	
			B. WIN			04/06/2	011
	PROVIDER OR SUPPLIER		•	2288 NI	DDRESS, CITY, STATE, ZIP CODE CHOLAS CT DUR, IN47274		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
		n.m. other CNA heard					
		going off we went					
		was sitting non side					
		o get upwas upset					
	saying her gra	ndpa needed her"					
	 "2/24/11 4 n n	Daggiyad gall from					
	_	n. Received call from nister [sic] stating					
	resident fell out of chair, upon arrival to facility assessed						
		request smaller					
		with non slick					
	surface."	Will Holf Silvik					
	Notes indicate	d the resident was					
	sent to the hos	pital 3/13/11 and					
	returned 3/24/	11.					
	"3/28/11 236 a	n.m. went to check on					
	resident found	on floor next to bed,					
	called EMS , t	hey put her back to					
	bed"						
		1 11 11 1011					
		eceived resident fell.					
		ice to discuss recent					
	_	ested home health					
	_	le evaluation for					
	· ·	l consideration to					
	anchor Foley of	catheter as resident					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD B. WING		00	(X3) DATE : COMPL 04/06/2	ETED
	PROVIDER OR SUPPLIER	2		2288 NI	DDRESS, CITY, STATE, ZIP CODE CHOLAS CT UR, IN47274		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	states she is go bathroom."	etting up to go to					
	The service pl interventions a prevention.	an included no added for falls					
	Director, on 4, she indicated to by a home hear physical and of therapies, but						
	#2 was review 10:00 A.M. T Resident #2 ha included, but w Chronic Pain a [high blood pr was observed A.M. in the fa	Il record of Resident red on 04/05/11 at the record indicated ad diagnoses that were not limited to, and Hypertension ressure]. Resident #2 on 04/05/11 at 10:45 cility courtyard electric wheelchair.					
	areas of burne	t 10:45 A.M., three d carpet were noted rea of Resident #2's					

PRINTED: 05/16/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00		E SURVEY PLETED	
			A. BUII B. WIN			04/06/	
NAME OF F	PROVIDER OR SUPPLIER		р. үн	STREET A	DUR, IN47274	I	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	apartment.						
	Service Plan of 03/15/11, indice was a smoker assistance with and smoke saft assistance outs smoking area, further indicate no problems we date, time, or left. The Resident State of 1/23/11 at 12 "Res. [resident BR [bathroom putting [sic] as commode. State is against facilities inside the built know but I can [name of Well and I go way be serviced].	nt and Negotiated f Summary, dated cated Resident #2 and required no n managing cigarettes fely and without side in designated The Service Plan ed Resident #2 had with recalling the day, ocation. Service Notes, dated :00 P.M., indicated, t] found smoking in] of apartment. shes and cigarettes in ff reminded res. this ity policy to smoke ding. Res. stated 'I n't go outside and ness Director] DoN back she knows in here and it ok with					
	The Resident	Service Notes, dated					

004376

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		NSTRUCTION 00	COMPL	ETED	
			B. WING			04/06/2	011
	PROVIDER OR SUPPLIEF S HOUSE	t.		2288 NI	DDRESS, CITY, STATE, ZIP CODE CHOLAS CT UR, IN47274		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.ΤΕ	(X5) COMPLETION DATE
	"Administrator smoking in bat Administrator a.m. CNA [Ce Assistant] to refurther smoking. The Resident 02/08/11 at 1: "Spoke with reabout only design was outside in re-educated at hazzerds [sic] understands slinside" The Resident 03/20/11 at 1: "Continues to her room during informed her to puts other residence Direction of puts other residence."	will address issue in artified Nursing monitor for any ng. Service Notes, dated 20 P.M., indicated, esident extensively signated smoking area the courtyard pout smoking. Resident states she he can not smoke Service Notes, dated 20 P.M., indicated, sneak cigarettes in ng third shift his could result in a notice because this dent at risk"					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				LDING	NSTRUCTION 00	(X3) DATE S COMPL 04/06/2	ETED
	PROVIDER OR SUPPLIER S HOUSE		·	2288 NI	DDRESS, CITY, STATE, ZIP CODE CHOLAS CT DUR, IN47274		
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TAG	spoken to Residence Office Smoking in he Residence Dirindicated he condocumentation. In an interview Nurse on 04/0 he indicated he provide a smooth Resident #2. The Policy and Smoking prov 04/06/11 at 10 "Smoking" smoke in outsionly7. a resident seems assessed during Service Plannia All incidents of should be door	ident #2 on or about 8/29/11 about r room. The ector further ould provide no n of the conversation. If with the Regional 6/11 at 11:00 A.M., e was unable to king assessment for dead by the RD on 1:00 A.M. indicated, and Residentmay ide designated areas sident's ability to be manner should be gethe Negotiated ingas needed. 8. of unsafe smoking umented intheir rvice Plan should be		TAG	DEFICIENCY)		DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MU	ILTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUIL		00	04/06/2011	
			B. WINC		DDRESS, CITY, STATE, ZIP CODE	0 1/00/2011	
NAME OF I	PROVIDER OR SUPPLIER				CHOLAS CT		
SHIELDS	HOUSE				UR, IN47274		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	Τ'	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL]	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF THE APPROPRIATE		
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	DATE	
R0217		pletion of an evaluation, the opriately trained staff					
		entify and document the					
	I	vided by the facility, as					
	follows: (1) The services o	ffered to the individual					
	resident shall be a						
	(A) scope;						
	(B) frequency; (C) need; and						
	(D) preference;						
	of the resident.						
	` '	ffered shall be reviewed propriate and discussed by					
	the resident and facility as needs or desires						
	change. Either the	facility or the resident may					
	request a service						
		on service plan shall be by the resident, and a copy					
	of the service plan	shall be given to the					
	resident upon requ						
	l ' '	n and documentation of is needed if evaluations					
	subsequent to the	initial evaluation indicate no					
	need for a change						
	` '	n of medications or the ential nursing services, or					
	l ·	licensed nurse shall be					
		cation and documentation of					
	the services to be Based on reco	•	RO	217		04/28/201	1
		facility failed to			Citation #2 R 217		
	l '	rice plan to include			410 IAC 16.2-5-2 (e) (1-5)		
	fall prevention	-			Evaluation What corrective action(s) will	he	
	pressure ulcer	interventions, for			accomplished for those resider		
	Resident #11 a	and for fall prevention			found to have been affected by	this	
	for Resident #	9 for 2 of 5 residents			deficient practice? No residents were found to be		
	reviewed for s	ervice plan updates			affected. Resident #9 and #11 w re-assessed by the Wellness Dir		
					10-assessed by the Weilliess Dil	CC101	

6JW011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULT	ΓIPLE CON		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	00	COMPLETED
			B. WING			04/06/2011
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE	
					CHOLAS CT	
SHIELDS	HOUSE			SEYMOU	JR, IN47274	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL	1	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	
TAG		LSC IDENTIFYING INFORMATION)	1 1	ΓAG	DEFICIENCY)	DATE
	and revisions i	n a sample of 7.			utilizing the service level assess and the negotiated service plan a	
					falls and pressure ulcer interven	
					Resident #11 had interventions	
	Eindings in als	da.			implemented to minimize the ris	sk for
	Findings inclu	de.			future falls and impaired skin	
					integrity along with a plan to	40
	1. Resident #1	1 was identified by			promote wound healing. Resider had interventions implemented t	
	the Wellness D	Director on the initial			minimize the risk for future falls	
	tour of the faci	lity on 4/5/11 at 9:30				
		dependent on staff			How the facility will identify of	
	-	ot interviewable.			residents having the potential t	to be
					affected by the same deficient practice and what corrective	
		vas observed from			action will be taken?	
	9:30 a.m. thro	ugh 12:30 p.m., to be			No other residents were found to	be l
	sitting in a hig	h back wheelchair in			affected.	
	the dining rooi	 n. A Foley catheter 			What measures will be put into	,
	drainage bag v	vas observed hanging			place or what systemic changes	
		air. At 1:30 p.m., a			will the facility make to ensure	
		urse was observed			that the deficient practice does recur?	not
					The Wellness Director and staff	were
	changing the d	•			re-educated to our policy and	
		neel. The area was			procedure regarding falls	
	observed to co	ver the entire heel,			management and service planning	- I
	with a open wo	ound, red base in the			order to ensure compliance with Indiana state ruling 410 IAC	
	center, loose, y	ellow skin			16.2-5-2 (e) (1-5) Evaluation. The	he
		e open area, with the			Wellness Director and/or Design	
	-	-			will review incident reports to e	nsure
		he yellow being a			appropriate evaluation of resider	I
	_	The home health			completed and documented with our service notes after falls.	nin
	nurse indicated	d the resident had			Residents experiencing a fall wi	11
	returned from	a hospital stay on			also have their service plans	
	3/28/11 with a	blister to the heel.			reviewed and updated to ensure	
	She further inc	licated she thought			appropriate interventions are	
					implemented in order to minimi	ze

004376

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S COMPL	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUIL		00	04/06/2	
			B. WING		ADDRESS, CITY, STATE, ZIP CODE	04/00/2	
NAME OF I	PROVIDER OR SUPPLIE	R			ICHOLAS CT		
SHIELDS	S HOUSE		SEYMOUR, IN47274				
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
IAG	.	,		IAG	the risk for future occurrences.		DATE
	the heel was a Stage 2 pressure ulcer and physical therapy was debriding it. In interview at this						
					How will the corrective action will be monitored to ensure the		
	_				deficient practice will not recu		
	time, the hom				i.e., what quality assurance		
		ne health provided all			program will be put into place	?	
	treatments for	the ulcer.			For the next three months the Wellness Director or designee v	vill	
					perform a random weekly revie		
	Resident #11's	s clinical record was			resident incident reports, service		
	reviewed on 4	1/5/11 at 11:00 A.M.			notes, and service plans to ensu residents who experience a fall		
	The most rece	ent Assessment and			evaluated with appropriate	are	
	Negotiated Se	ervice Plan Summary,			documentation and service plan	-	
	_	0, indicated "staff to			as to interventions attempted in to minimize the risk for future f		
		pathing twice weekly"			Findings will be reviewed within		
	_	ical assist with			next three months as to the freq	-	
		able to use the			of continued monitoring. Findir suggestive of compliance will n		
	_	ependently, uses			the criteria for cessation of our		
		dergarments, needs			weekly review. Resident's will		
	_	catheter drainage			reviewed ongoing upon admissi and as needed and corrected thr		
		ssist with catheter.			the facility's QA process.		
		ery shift, uses a			Dy what data will the and		
	1 1 2 0	anual wheelchair for			By what date will the systemic changes be completed?		
		dent requires staff to			Compliance Date: May 15, 201	.1	
	I	-					
		for exercise, activities					
	1	uently as she gets					
		t being able to find					
	_	assistance of two					
	personnel or t						
		ft for transfers, staff					
	must assist ho	me health with					

004376

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUII	LDING	NSTRUCTION 00	(X3) DATE: COMPL 04/06/2	ETED	
	PROVIDER OR SUPPLIEF		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE CHOLAS CT DUR, IN47274	1 0 11 0 0 12	<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΛΤΕ	(X5) COMPLETION DATE
	keep resident of services-home outside provide anxious at time be calmed by a A nursing come valuation, dathe resident has hospital stay with blister yellowing evaluation industried of order lethargic and of when she is stable. A home health indicated "Pt states of the states of th	health or other der, resident becomes es and may need to staff. Inprehensive ted 3/24/11, indicated and returned from a with a 7 cm left heel sh closed. The icated home health ders and "resident only opens her eyes imulated" In note, dated 3/29/11, sent tohospital on					

	OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA UDENTIFICATION NUMBER:	(X2) MULTIPLE CON A. BUILDING	00	COMPLETED
		B. WING		04/06/2011
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, STATE, ZIP CODE	
SHIELDS	HOUSE	2288 NICHOLAS CT SEYMOUR, IN47274		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE COMPLETION DATE
1710	hospitalized for exacerbation of	ind	<u> </u>	DATE
	Alzheimer's and was released			
	before home health was			
	notifiednow has decreased self			
	care abilitywith large open blister			
	on left heelPhysical therapy for			
	evaluation with wound care. Notes,			
	dated 3/30/11, indicated physical			
	therapy would see the resident one			
	time weekly for six weeks for			
	management of left heel wound to			
	include sharp debridement as			
	indicated, dressing changes as per			
	orders, cleanse left heel with			
	normal saline, apply Allevyn foam			
	and calcium alginate. secure with			
	Kerlix and tape. Assess wound:			
	pressure ulcer left posterior heel,			
	unstageable, suspected deep tissue			
	injury, .79 in length and .98 in			
	width, small amount exudate, tissue			
	bed-pink, red, dark red.			
	The record lacked any			
	documentation of what the pressure			
	area looked like between 3/28/11			
	and when assessed by home health			
	on 3/29/11, or any interventions			
	implemented. The facility lacked			
	implemented. The facility facked			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			LDING	nstruction 00	COMP:	LETED	
			B. WIN			04/06/2	2011
NAME OF F	PROVIDER OR SUPPLIER	<u>.</u>			ADDRESS, CITY, STATE, ZIP CODE		
	S HOUSE			1	CHOLAS CT DUR, IN47274		
		TEATER OF DEPLOYER OF DEPLOYER OF		<u> </u>	JUR, IN47274		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION
TAG	·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	PRIATE	DATE
	any service pla	an to treat the					
	pressure ulcer						
	During intervi	ew with the Wellness					
	Director, dated	d 4/5/11 at 11:45					
	A.M., indicate	ed she had given the					
	Health Facility	y Administrator some					
	updates on the	e service plans to type					
	in but those co	ould not be located.					
	Resident Serv	ice Notes indicated					
	the following:						
	"7/13/11 staff	entered resident room					
	to empty cathe	eter, resident was on					
	floor next to b	ed feet toward bed					
	head toward c	loset, chair was					
	turned over in	from of her, EMS					
	(emergency m	edical cal services)					
	was called, the	ey checked her over					
	and assisted up	p"					
	•	o.m. res [resident]					
		by CNAsent to					
	-	back to facility 9					
	_	to bathroom by CNA					
	and helped get	t ready for bed"					
	9/8/10 3:30 p.:	m. Res got up by self					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE COMPI		
AND FLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUII		00	04/06/2	
			B. WIN		DDRESS, CITY, STATE, ZIP CODE	1 0 0 0 2	
NAME OF I	PROVIDER OR SUPPLIEF	₹			CHOLAS CT		
SHIELDS	S HOUSE				DUR, IN47274		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, i	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	from dining ro	oom and fell"					
		0 p.m. doing rounds					
		on floor toward foot					
	of bed ed cryi	ng and					
	shakingdispa	atched 9113 A.M.					
	call (hospital)	they will be keeping					
	her she has a b	oroken left hip"					
	"10/8/10 230 1	p.m. spoke					
	withdischar	ge plannerrequested					
	low hospital b	ed and wheelchair					
	_	onable fracture of left					
	hip"						
	F						
	A note dated	10/10/10 at 7 p.m.,					
	indicated the r	* '					
		he hip causing severe					
	pain not a frac						
	pneumonia.	rure and nad					
	piicumoma.						
	 "10/13/10 8 p.	m assisted to					
	1 ^	n assist of 2 some					
	1	sferring resident					
		ng, pushing against					
	staff"						
	N1 /1 4 /11 050	4 00141 1					
		a.m. other CNA heard					
	ner bed alarm	going off we went					

NAME OF PROVIDER OR SUPPLIER SHIELDS HOUSE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG (FORSS-REFERENCED TO THE APPROPRIATE DATE) into room she was sitting on side of bed trying to get upwas upset saying her grandpa needed her" "2/24/11 4 p.m. Received call from resident administer [sic] stating resident fell out of chair, upon arrival to facility assessed residentwill request smaller cushion depot with non slick surface." A. BUILDING D4/06/2011 STREET ADDRESS, CITY, STATE, ZIP CODE 2288 NICHOLAS CT SEYMOUR, IN47274 PROVIDERS RAN OF CORRECTION (X5) COMPLETION (FACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE) CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DA	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				00	COMPI	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2288 NICHOLAS CT SEYMOUR, IN47274 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG Into room she was sitting on side of bed trying to get upwas upset saying her grandpa needed her" "2/24/11 4 p.m. Received call from resident administer [sic] stating resident fell out of chair, upon arrival to facility assessed residentwill request smaller cushion depot with non slick STREET ADDRESS, CITY, STATE, ZIP CODE 2288 NICHOLAS CT SEYMOUR, IN47274 ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTION OF CORRECTION OF COMPLETION DESCRIPTION OF COMPLETION DATE) PROVIDE STATE AND FORMACTION SHOULD BE COMPLETION DATE (X5) COMPLETION DATE 1 PROVIDE STATE AND FORMACTION SHOULD BE COMPLETION OF CORRECTION (EACH CORRECTION SHOULD BE COMPLETION DATE) 1 PREFIX TAG PROVIDES PLAN OF CORRECTION (EACH CORRECTION SHOULD BE COMPLETION DATE) COMPLETION DATE 1 PROVIDES PLAN OF CORRECTION (EACH CORRECTION SHOULD BE COMPLETION DATE) COMPLETION DATE 1 PROVIDES PLAN OF CORRECTION (EACH CORRECTION SHOULD BE COMPLETION DATE COMPLETION DA						04/06/2	2011
SHIELDS HOUSE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) into room she was sitting on side of bed trying to get upwas upset saying her grandpa needed her" "2/24/11 4 p.m. Received call from resident administer [sic] stating resident fell out of chair, upon arrival to facility assessed residentwill request smaller cushion depot with non slick 2288 NICHOLAS CT SEYMOUR, IN47274 ID PROVIDERS PLAN OF CORRECTION (ICACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERENCED TO THE APPROPRIA	NAME OF F	PROVIDER OR SUPPLIER	<u> </u>	 	ADDRESS, CITY, STATE, ZIP CODE	_!	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Into room she was sitting on side of bed trying to get upwas upset saying her grandpa needed her" "2/24/11 4 p.m. Received call from resident administer [sic] stating resident fell out of chair, upon arrival to facility assessed residentwill request smaller cushion depot with non slick ID PROVIDERS PLANOF CORRECTION (X5) COMPLETION DATE COMPLETION DATE COMPLETION DEFICIENCY CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY COMPLETION DATE COMPLETION DEFICIENCY CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY COMPLETION DEFICIENCY CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY COMPLETION DEFICIENCY COMPLETION DATE COMPLETION DEFICIENCY COMPLETION DEFICIENCY			•	1			
PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Into room she was sitting on side of bed trying to get upwas upset saying her grandpa needed her" "2/24/11 4 p.m. Received call from resident administer [sic] stating resident fell out of chair, upon arrival to facility assessed residentwill request smaller cushion depot with non slick COMPLETION DATE PREFIX TAG COMPLETION DATE COMPLETION DATE			TEATEN FENTS OF DEFICIENCIES	 <u> </u>	JUR, IN47274		T (7/5)
into room she was sitting on side of bed trying to get upwas upset saying her grandpa needed her" "2/24/11 4 p.m. Received call from resident administer [sic] stating resident fell out of chair, upon arrival to facility assessed residentwill request smaller cushion depot with non slick					(EACH CORRECTIVE ACTION SHOULD B)	E	1 ' '
bed trying to get upwas upset saying her grandpa needed her" "2/24/11 4 p.m. Received call from resident administer [sic] stating resident fell out of chair, upon arrival to facility assessed residentwill request smaller cushion depot with non slick	TAG			TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
saying her grandpa needed her" "2/24/11 4 p.m. Received call from resident administer [sic] stating resident fell out of chair, upon arrival to facility assessed residentwill request smaller cushion depot with non slick		into room she	was sitting on side of				
"2/24/11 4 p.m. Received call from resident administer [sic] stating resident fell out of chair, upon arrival to facility assessed residentwill request smaller cushion depot with non slick		bed trying to g	get upwas upset				
resident administer [sic] stating resident fell out of chair, upon arrival to facility assessed residentwill request smaller cushion depot with non slick		saying her gra	ndpa needed her"				
resident administer [sic] stating resident fell out of chair, upon arrival to facility assessed residentwill request smaller cushion depot with non slick							
resident fell out of chair, upon arrival to facility assessed residentwill request smaller cushion depot with non slick		"2/24/11 4 p.n	n. Received call from				
arrival to facility assessed residentwill request smaller cushion depot with non slick		resident admir	nister [sic] stating				
residentwill request smaller cushion depot with non slick		resident fell or	ut of chair, upon				
cushion depot with non slick		arrival to facil	ity assessed				
		residentwill	request smaller				
surface."		cushion depot	with non slick				
		surface."					
Notes indicated the resident was		Notes indicate	ed the resident was				
sent to the hospital 3/13/11 and		sent to the hos	spital 3/13/11 and				
returned 3/28/11.		returned 3/28/	11.				
"3/28/11 236 a.m. went to check on							
resident found on floor next to bed,			,				
called EMS, they put her back to		ŕ	they put her back to				
bed"		bed"					
3/28/11 call received resident fell.							
call to Droffice to discuss recent							
falls and requested home health		•					
referral possible evaluation for		_					
safety mat and consideration to		~					
anchor Foley catheter as resident							
states she is getting up to go to		_	etting up to go to				
bathroom."		bathroom."					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					NSTRUCTION 00	(X3) DATE	SURVEY LETED
			A. BUI B. WIN	LDING IG		04/06/2	
			B. WIN		DDRESS, CITY, STATE, ZIP CODE		
	PROVIDER OR SUPPLIEF	(2288 NI	CHOLAS CT		
SHIELDS	HOUSE			SEYMO	OUR, IN47274		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD)		(X5)
PREFIX TAG	· ·	NCY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROF		COMPLETION DATE
		,					
	The service pl	an included no					
	interventions a						
	prevention.						
	provention.						
		l record for Resident					
		ved on 4/5/11 at 11:00					
		ord indicated Resident					
	_	oses that included, but					
		ed to, diabetes and					
	depression.						
		ent and Negotiated					
		Summary, dated					
		ted "Have you ever					
	· ·	was a x in the box					
	_	estion with no other					
	documentation	n)"					
		Services Notes, dated					
		A.M., indicated					
	•	d Rd [resident] found					
		nt of commode. Upon					
	_	Rd sitting on floor					
	_	ode. Rd A & O x 3					
	[alert and orie	nted times three].					
	Denies hitting	head. Denies any					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE COMP			
			A. BUII B. WIN	LDING IG		04/06/2	2011	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2288 NICHOLAS CT SEYMOUR, IN47274					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
	injuryRd unsure how she feel off commode. States "I was sitting on the commode my clothes were on							
	the floorI rea	ached down and on floor""						
	The Resident Services Notes, dated 9/21/10 at 6:00 P.M., indicated "Res called me to room, found on							
	floor, went got nurse to assess. Res stated she wasn't hurtno apparent injury. Notified Adm [administrator], regional RN, and family. Faxed MD." The Resident Services Notes, dated 9/27/10 at 5:00 A.M., indicated "Resident was found on floor in front of room door in hallway saying help. Immediately asked if she was OK. (Name) picked her up and sat her in chair. She said she was OK. I then called her son. I then told him that his mother had fallen off couch and I had seen her on floor in hall by her door. He asked if she was OK. I said yes and							
	then told him	that (name) had when she said she						

PRINTED: 05/16/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDI		NSTRUCTION 00	(X3) DATE S COMPL 04/06/2	ETED	
	PROVIDER OR SUPPLIEF	 	2	2288 NI	DDRESS, CITY, STATE, ZIP CODE CHOLAS CT UR, IN47274		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID EFIX CAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
IAU	was OK. He stold him that I fell, got in hal pendant was. I then asked for called and information on or for anyone help her up after and got dressed dining area for In an interview Nurse, on 4/6/indicated the president #9 or was a visitor. The Resident 9/27/10 at 1:00 [resident] on statistically. Appear w/c. denies part of the Resident 9/30/10 at 1:00 [resident] on statistically. Appear w/c. denies part of the Resident 9/30/10 at 1:00 [resident] on statistically. Appear w/c. denies part of the Resident 9/30/10 at 1:00 [resident] on statistically. Appear w/c. denies part of the Resident 9/30/10 at 1:00 [resident] on statistically. Appear w/c. denies part of the Resident 9/30/10 at 1:00 [resident] on statistically appear w/c. denies part of the Resident 9/30/10 at 1:00 [resident] on statistically appear w/c. denies part of the Resident 9/30/10 at 1:00 [resident] on statistically appear w/c. denies part of the Resident 9/30/10 at 1:00 [resident] on statistically appear w/c. denies part of the Resident 9/30/10 at 1:00 [resident] on statistically appear w/c. denies part of the Resident 9/30/10 at 1:00 [resident] on statistically appear w/c. denies part of the Resident 9/30/10 at 1:00 [resident] on statistically appear w/c. denies part of the Resident 9/30/10 at 1:00 [resident] on statistically appear w/c.	aid it was fine. I also asked her how she I and where her He said all right. She coffee after I had bormed (Residence he) about incident. efused to be sent out me to be called to the coffee she went had and came back to a while." We with the Regional 11 at 10:00 A.M., he berson which assisted ff the floor on 9/27/10 Services Notes, dated 0 P.M., indicated "Rd hidewalk in front of hars to have slid out of		AU			DATE

004376

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CC A. BUILDING B. WING	00	li i	e survey pleted /2011
NAME OF F	PROVIDER OR SUPPLIER S HOUSE		2288 N	ADDRESS, CITY, STATE, ZIP CO ICHOLAS CT DUR, IN47274	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
IAU	denies injury a ER. Moves all [extremities]w Assisted to w/ to toilet from y The Resident a 10/7/10 at 1:30 "Res paged Cl was cleaning l slipped on a m hitting her hea refused to go t Signed refusal signs within N (name) W/D [(name) R/D [Son (name) am notified. Res a hip and R thig falls" The Resident A Negotiated Se dated 11/3/10,	and refused to go to ext without difficulty c res transferred self w/c without difficulty Services Notes, dated O P.M., indicated NA, Res stated she her room when she hagazine and fell id on A/C unit. Res to ER for exam. Ito transport. Vital I/L [normal limits]. Wellness Director], Residence Director], id Dr (name) all hlso stated R [right] h hurt from previous Assessment and rvice Plan Summary,	IAG			DATE
	months. The Resident	Services Notes, dated				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUI A. BUILD		NSTRUCTION 00	(X3) DATE S		
			B. WING			04/06/2	011
	PROVIDER OR SUPPLIER			2288 NI	DDRESS, CITY, STATE, ZIP CODE CHOLAS CT UR, IN47274	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	regulatory or 11/10/10 at 7:2 "Res pushed proceed what res in buttocks in from R [right] kneed into B/R [bath and got nurse assess and we area on buttoche refused to go to transport. Contame) W/D [Contame) RD [Roname) Region (name)." The Nursing Contame Proceeding to the Nursing Contame Procedure of the Nursing Contame Procedur	endant, CNA went to eeded, found res on ont of door. Res stated gave out, when going room]. CNA went (name) nurse did got res up. No red ks denies painRes to ER signed refusal alled son (name), Wellness Director], esidence Director], and Nurse and Dr			CROSS-REFERENCED TO THE APPROPRIA	TE	
	The Resident 11/24/10 at 7::	Services Notes, dated 50 (no A.M. or P.M.), led to res room CNA					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING B. WING	00	li i	E SURVEY PLETED /2011			
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 2288 NICHOLAS CT SEYMOUR, IN47274					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
	Upon entering	nt # 9) is in the floor. the room res sitting						
	l	nt of sofa with back Res denies hurting tting head"						
	"Res [resident went to room front of couch what happened ER called her picked her updirector] and I director] calle aware no injure.	d Dr. faxed. Family ry noted at this time."						
	1/10/11, no tir "Responded to name) room- of sitting on floot the closet door resident- she st unplugging he she lost her ba	o (Resident #9's observed resident r between her bed and rs. Examined tated she was or electric w/c when lance. Denies pain or d is refusing transport						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC A. BUILDING B. WING	NSTRUCTION 00		E SURVEY PLETED /2011			
	PROVIDER OR SUPPLIER	.	STREET ADDRESS, CITY, STATE, ZIP CODE 2288 NICHOLAS CT SEYMOUR, IN47274					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
	assessmentS observed L [le	Small 1.5 cm skin tear eft] wrist"						
	1/19/11 at 2:1 "Resident turn when CNA en on floor sitting wicker rocker said she was g missed the char going to sit do chair. She use to help pull he to go to ER sa apparent injur called, Resident's son. The Resident 1/19/11 at 4:3 "Call resident floor in her ropain or discontransported to for assessmen erythemia (sic R/T [related to	Services Notes, dated 5 A.M., indicated ned call pendant on tered room she was g up in living room. A was laying on her she going to sit down and air. She said she was own and missed the d the arm of the chair erself up. She refused iid she wasn't hurt. No ies at this timeRN nt Director called, a called. Dr notified." Services Notes, dated 0 A.M., indicated had been found on om. Assessed- no c/o nfort refusing to be the emergency room t. No areas of e), or skin break down of fallDiscussed the desire for her to						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 00	COMPL 04/06/2	ETED	
	PROVIDER OR SUPPLIEF			2288 NI	DDRESS, CITY, STATE, ZIP CODE CHOLAS CT DUR, IN47274	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	Resident state decreased feel her neuropath	ance when needed. Is she feels she has ing in her feet from y. I informed her that more important to call					
	1/31/11 at 8:40 "Called to resident. Obse	Services Notes, dated O A.M., indicated dent's room to assess rved resident on the front of her couch. dent- denies pain or					
	2/8/11 at 7:15 "Received a can was found sittle refused ER [entransport and lacalled to help by resident. Uresident's room sitting on her what happened "had just sat definition of the content of the co	n she was already couch. Discussed d and she stated she own too soon."					
	The Resident	Services Notes, dated					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S COMPL	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUIL		00	04/06/2	
			B. WINC		ADDRESS, CITY, STATE, ZIP CODE	0 0 0 =	
NAME OF F	PROVIDER OR SUPPLIER				ICHOLAS CT		
	HOUSE				OUR, IN47274		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
		A.M., indicated "Dr					
		d of fall and asked					
	` /	appointment so he					
	_	recent falls"					
	The Resident S	Services Notes, dated					
	2/8/11, no time	e, indicated "Resident					
	fell- assessed.	No c/o [complaints					
	of] pain or disc	comfort. No bruising,					
), abrasion observed."					
		, ,					
	The Resident S	Services Notes, dated					
	2/13/11, no tin	ne, indicated					
	"Resident fell	in bathroom- stated					
	she did not kno	ow how she got on					
		r. Family called and					
		nt up. Small 1 x [by]					
		right] side of head ice					
		ed transport to					
		om for assessment."					
	<i></i>						
	The Resident A	Assessment and					
	Negotiated Ser	rvice Plan Summary					
	_	entation of updates or					
	revisions since	•					
	In an interview	w with the Wellness					
	Director on, 04/06/11 at 10:00						
	· ·	cated the Resident					

l	OF CORRECTION	IXI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING B. WING	00 	l l	ESURVEY PLETED 2011		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2288 NICHOLAS CT SEYMOUR, IN47274					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
	Assessment ar	nd Negotiated Service v, dated 11/03/10, was						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A BUILDING 00			COMPL	3) date survey completed 04/06/2011	
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2288 NICHOLAS CT SEYMOUR, IN47274				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI TAG DEFICIENCY)		Έ	(X5) COMPLETION DATE
R0239	administers medic nursing care, or bot delineated in the factearly stated in the Based on obse and record rev failed to ensur QMA's [Quali Aides] administance accordance with medication point medications with the physicians of facility allower and personal faction without checking labels for 2 of for medication sample of 7. (Findings inclusions and personal factions are detected in the policy and personal factions are detected in the faction and personal factions are detected in the faction of the policy and personal factions are detected in the faction of the policy and personal factions are detected in the faction of the policy and personal factions are detected in the faction of the policy and personal factions are detected in the faction of the policy and personal factions are detected in the faction of the policy and personal factions are detected in the faction of the policy and personal factions are detected in the faction of the policy and personal factions are detected in the faction of the policy and personal factions are detected in the faction of the policy and personal factions are detected in the faction of the policy and personal factions are detected in the faction of the policy and personal factions are detected in the faction of the policy and personal faction of the policy and personal factions are detected in the faction of the policy and personal faction of the personal f	licies to assure ere given according orders; in that the d family members riends to set up xes from which staff he medications ing the medication 5 residents reviewed administration in a Resident #2 and #10) de: I procedure for stribution Methods, the Wellness 4/11, not dated,	RO	0239	Citation #3 R 239 410 IAC 16.2-5-4 (c) Health Services What corrective action(s) w be accomplished for those residents found to have bee affected by this deficient practice? No residents were found to be affected. Resider and #10 were re-assessed by Wellness Director utilizing the medication self administration assessment. Resident #2 and #10 were deemed to be inca of self administration of medication. The resident's physician was notified with a order obtained for Shields Ho licensed staff to admin medications per physician or Resident #2 and #10 had the service plan updated to inclu Residence to administer medication as indicated by the physician. How the facility we identify other residents have the potential to be affected the same deficient practice what corrective action will be taken? No other residents we found to be affected. What measures will be put into pl or what systemic changes we the facility make to ensure to the deficient practice does recur? The Wellness Director	ill en ht #2 y the en d pable nouse der. eir de iing by and pe ere ace vill that not	04/28/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA						(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED		
			B. WIN			04/06/2011		
NAME OF I				STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIER			2288 NI	ICHOLAS CT			
	HOUSE				DUR, IN47274			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE COMPLETION DATE		
IAG		administered to		IAG	and staff were re-educated to			
	residents as determined by review			policy and procedure regarding				
		ation status and in			falls management and service planning in order to ensure	e		
					compliance with Indiana state	e		
		th physician orders,			ruling 410 IAC 16.2-5-2 (e) (1-5)		
	· ·	w and regulations.			Evaluation. The Wellness Director and/or Designee will re	eview		
	_	of medication and			incident reports to ensure appro	ı		
		are observed-right			evaluation of residents is compl			
	resident, right	medications, right			and documented within our serv notes after falls. Residents	vice		
	dose, right for	m and right route			experiencing a fall will also have	ze.		
					their service plans reviewed and			
	The policy and	d procedure for			updated to ensure appropriate			
	1 1	f Management of			interventions are implemented in order to minimize the risk for fu	ı		
		not dated, with a			occurrences.	iture		
	· ·	4/5/11, obtained from						
		Director on 4/6/11 at			How will the corrective action			
					will be monitored to ensure the deficient practice will not recu			
	9:30 A.M., ind				i.e., what quality assurance	,		
		f administration			program will be put into place			
	assessment, sh	lows that the resident			The Wellness Director or design will perform an ongoing quarter			
	should be capa	able of self			assessment of residents who sel	·		
	administering	medications, the			administer medications utilizing	g the		
	nursewhen	developing a plan for			medication self administration assessment to ensure continued			
	residents who	need reminders to			compliance. Findings will be			
	self administer	the medications that			reviewed and corrected through	the		
		neir apartments, be			facility QA process.			
		-			By what date will the systemic			
	sure to address any potential problems in the Negotiated service Plan. For example, when				changes be completed?			
					Compliance Date: May 15, 201	11		
	medications ar	-						
		•						
	meui-piaimei	be sure to address on						

004376

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	00		COMPL	ETED	
			B. WIN				04/06/2	011
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STA	ΓE, ZIP CODE		
SHIELDS	S HOUSE			1	UR, IN47274			
(X4) ID		TEMENT OF DEFICIENCIES		ID		LAN OF CORRECTION		(X5)
PREFIX TAG	,	MUST BE PERCEDED BY FULL C IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCE	E ACTION SHOULD BE D TO THE APPROPRIAT CIENCY)	E	COMPLETION DATE
		the family member						
	responsible for s	setting them up						
	accurately and c	oming in to the						
	residents to rese	t them after a spill						
	or change in phy	sician orders. If						
	staff is to remine	d a self-med						
	resident that it is	s time to take						
	medications, the	MAR entry the						
	staff will initial	might read: staff to						
	remind resident	of medication						
	times, then list t	he times staff will						
	perform taskN	ote: Under no						
	circumstance sh	ould staff open a						
	medi-planner an	d assist with						
	medication adm	inistration if the						
	medi-planner is	filled by someone						
	other than a nurs	se"						
	1. During obser	vation of the						
	medication pass	on 4/5/11 at 9:30						
	A.M., QMA #1,	indicated she was						
	going to adminis	ster Resident 10's						
	medications. Q	MA #1 took a						
	weekly medi-pla	anner (a plastic						
	container used to	o set up						
	medications with	h 4 times for each						
	of the 7 days) or	it of the medication						
	1	ove 11 medications						
	from the contain							
FORM CMS-2	2567(02-99) Previous Versions	Obsolete Event ID:	I 6JW011	Facility I	D: 004376	If continuation sh	neet Pa	l ge 35 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S COMPLE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUIL		00	04/06/20	
			B. WING		ADDRESS, CITY, STATE, ZIP CODE	0 11 00120	
NAME OF I	PROVIDER OR SUPPLIER				ICHOLAS CT		
	S HOUSE				OUR, IN47274		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5)
TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG			COMPLETION DATE
-	indicated the resident's family set			_			
	the medication	s up and then facility					
	staff administe	ered the medications					
	and signed off	on the Medication					
	Administration	n Record as having					
	done so. No n	nedication bottles					
	were in the me	edication cart.					
	During interview with Resident #10 on 4/4/11 at 10:30 A.M., she						
	indicated she r	eally did not know					
	what all the m	edications were she					
	took. She indi	cated her husband					
	used to set up	her medications and					
	now one of he	r children did. She					
	indicated she v	would not want to					
	have the week	ly box set up and take					
	them herself in	her room. She					
	indicated all th	ne medications were					
	kept in her bat	hroom in a cabinet.					
	The medicatio	ns were observed					
	with labels ava	ailable.					
	Resident #10's	clinical record was					
	reviewed on 4	/4/11 at 10:00 A.M.					
	Diagnoses incl	luded but were not					
	limited to: Der	mentia. The					
	resident's Med	icating Self					
	Administration	n assessment, dated					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC A. BUILDING B. WING	00	li i	e survey pleted /2011	
	PROVIDER OR SUPPLIER		STREET A 2288 N	ADDRESS, CITY, STATE, ZIP O ICHOLAS CT DUR, IN47274	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
TAG	1/29/11, indicated apable of self form was not of indicated if the participate in palso included a "Plan" and "Coneither were continued and indicated under assistance," It to manage you independently set up, taking medications. Freminders only take your mediable to order, all medication supervision)," "no." The April 201 Administration	ated the resident was administering, the completed to be resident "chooses to program." The form a section entitled comments," and completed. See sees sment/Negotiated dated 1/29/11, ber "medication me resident was able	TAG		APPROPRIATE	DATE
	[sic] [for Diab [milligrams] d					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO.	NSTRUCTION 00	COMPL		
THEFTERN	or condition	DENTIFICATION NO MBER.	1	LDING		04/06/2	
			B. WIN	_	DDRESS, CITY, STATE, ZIP CODE	1	
NAME OF F	PROVIDER OR SUPPLIER			1	CHOLAS CT		
SHIELDS	SHOUSE			SEYMO	UR, IN47274		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			COMPLETION DATE
	Hydroxyzinep	am [sic] [for Seasonal					
	Allergies] 25 r	ng twice daily,					
	Aricept [for D	ementia] 5 mg daily,					
	Lasix [a diure	tic] 40 mg daily,					
	Metformin [fo	r Diabetes] 500 mg					
	daily, Tylenol	Arthritis [for pain]					
	650 mg twice	daily, Detrol LA [for					
	urinary reflux]	4 mg daily,					
	Glipizide ER [for Diabetes] 10 mg						
	twice daily, Nexium DR [for						
	1 .	geal Reflux Disease]					
	40 mg daily, P						
	_	atory] 5 mg daily,					
		[for depression] 100					
	mg daily."						
	2. The clinical	record of Resident					
	#2 was review	ed on 04/05/11 at					
	10:00 A.M. T	he record indicated					
	Resident #2 ha	nd diagnoses that					
	included, but v	were not limited to,					
	Chronic Pain a	and Hypertension					
	[high blood pr	essure]. Resident #2					
	was observed	on 04/05/11 at 10:45					
	A.M., in the facility courtyard						
	sitting on her	electric wheelchair.					
	On 04/05/11 a	t 9:45 A.M., QMA #1					
	was observed	, ,					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	IULTIPLE CO	OO	(X3) DATE COMPI		
ANDILAN	OF CORRECTION	IDENTIFICATION NOVIDER.		LDING	00	04/06/2	
			B. WIN		DDDDGG GWY GWW GODD	04/00/2	.011
NAME OF F	PROVIDER OR SUPPLIEF	2		1	ADDRESS, CITY, STATE, ZIP CODE		
SHIELDS	SHOUSE				OUR, IN47274		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE		DATE
	1 *	from the medication					
		ection, pour the					
	contents into a	n medication cup, and					
	dispense the p	ills to Resident #2.					
	The Assessme	ent and Negotiated					
		of Summary, dated					
		cated Resident #2					
	· ·						
	required assistance with administration or supervision of 10						
		e medications per					
	day or more th	nan 4 medication					
	assistance tim	es per day. The					
	Service Plan f	urther indicated					
	Resident #2 ha	ad no problems with					
		lay, date, time, or					
	location.						
	100011.						
	In an interview	w with Resident #2 on					
	04/05/11 at 10	· · · · · · · · · · · · · · · · · · ·					
		ated a friend sets up					
		ications and gives the					
	pill box to the	nurses to give to her.					
	A physician fa	x transmission/phone					
	order, dated 02	2/22/11, indicated,					
	· ·	es. [resident] is now					
		er med by staff at this					
	time."	or med by start at time					
	tillic.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION 00	li i	(X3) DATE SURVEY COMPLETED		
	2. 20.110.1	The state of the s	A. BUILDING B. WING		I	6/2011	
				T ADDRESS, CITY, STATE, ZII	P CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹	2288	NICHOLAS CT			
SHIELDS	S HOUSE		SEYN	MOUR, IN47274			
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TI DEFICIENCY	HE APPROPRIATE	COMPLETION DATE	
	 The Physician	's Order Recap for					
	· ·	10 indicated an order					
	for "Self admi	nistration of meds:					
	Yes was circle						
	The Physician	's Order Recap for					
	March 2011 w	as reviewed on					
	04/05/11 at 10:00 A.M., and indicated, "Ancillary Orders Self Administration of Meds: Yes No."						
	The document	t lacked any					
	indication that	t Yes or No had been					
	chosen by the	physician.					
	The Medication	on					
	Self-Administ	ration Assessment,					
	dated 12/31/08	8, indicated					
	"Physician agi	rees for resident to					
	self administer	r"					
	The Medication						
		ration Assessment,					
		1, indicated Resident					
	_	sistance with "5. Tell					
		n medication is					
		ve med from card or					
	bottle9. Phy	·					
	psychological	ly handle taking own					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	NSTRUCTION 00	COMPI		
			B. WING 04/06/2011				
NAME OF F	PROVIDER OR SUPPLIER	<u>.</u>	<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
	S HOUSE		2288 NICHOLAS CT SEYMOUR, IN47274				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	,		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOULD BE ACTION			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IAIE	DATE
	meds10. Ma	intain safe storage of					
	medication as	required by policy					
	and state regu	lations." The					
	assessment in	cluded a handwritten					
	note which inc	dicated, "Plan to					
	contact [name	of physician] and					
	request order t	to allow staff to take					
	over resident's	medication."					
	The Medication						
	Self-Administ	ration Assessment,					
	dated 04/05/11	I, indicated Resident					
	#2						
	"at times is	drowzy [sic] and has					
	to be awakene	d to take her					
	medications.	Shields House staff					
	have been adn	ninistering					
	medication"	S					
	The Nurses no	otes from 01/10/11					
	through 03/20	/11 and lacked					
	_	n that an order had					
	been obtained						
	administer me	dications.					
	The Nursing (Comprehensive					
	Evaluation, da	•					
	indicated, "QN						
		de] administering					
	1,10dication / I						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED				
ANDILAN	OF CORRECTION	IDENTIFICATION NOWIDER.	A. BUII			04/06/2011
			B. WIN	_	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER				CHOLAS CT	
SHIELDS	SHOUSE			SEYMO	DUR, IN47274	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION DATE
	medication".	,				
	The April 2011	1 MAR [Medication				
	_	n Record] indicated				
	Resident #2 re	ceived "Neurontin				
	[for pain] 300	mg [milligrams]				
	orally twice da					
	[supplement] 1	10 meq				
	[milli-equivalent] orally twice daily, Synthroid [hormone					
	supplement]] 1	175 mcg				
	[micrograms]	orally daily,				
	Metformin [fo	r diabetes] 500 mg				
	daily, Metopro	olol [for blood				
	pressure] 25 m	ng daily, Altace [for				
	high blood pre	essure] 2.5 mg daily,				
	Multivitamin [[supplement] daily,				
	Caltrate-600 w	vith Vitamin D [for				
	calcium replac	cement] daily, Celexa				
	[for depression	n] 10 mg daily, Evista				
	[for osteoporo	sis] 60 mg daily,				
	Famotidine [fo	or heartburn] 20 mg				
	daily, Durages	sic [for pain] 75 mcg				
	every 72 hours	s, Lasix [for edema]				
	80 mg daily, A	Albuterol 0.083% [for				
	asthma] by nel	bulizer twice daily,				
	Trazadone [for	r depression] 50 mg				
	at bedtime, Mi	iralax [for				
	constipation] 1	l tablespoon in water				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/06/2011		
	PROVIDER OR SUPPLIER S HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 2288 NICHOLAS CT SEYMOUR, IN47274				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF COI PREFIX (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE TAG DEFICIENCY)		(X5) COMPLETION DATE		
	Handbook page on 04/05/11 at indicated, "The administration give the right of label against the container of drug drawer, a remove the do and, finally, be container to the it. Never give	sing Spectrum Drug ge xiv was reviewed 2:15 P.M., and e 'five rights' of drugto make sure you drug, match the drug he order in the MAR ce when you remove from the patient's gain before you se from the container efore you return the e drawer or discard a drug from a is unlabeled"					
R0295	and use prescripti medications in the them secured from Based on inter review, the fact a resident follo procedure for	rview and record cility failed to ensure owed the facility storing medications, at #8 stored narcotics making them other staff and	R0295	Citation #4 R 295 410 IAC 16.2-5-6 (a) Pharmaceutical Services What corrective action(s) will accomplished for those resider found to have been affected by deficient practice? No residents were found to be affected. Resident #8 was	nts		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

6JW011

Facility ID:

004376

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	A. BUILDING 00 COMPL			
			B. WING			04/06/2	011
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREET AI	DDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIER			2288 NIC	CHOLAS CT		
SHIELDS	SHOUSE			SEYMO	UR, IN47274		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		Pl	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	reviewed for r	nedication storage in			re-educated to our policy and		
	a sample of 7.				procedure concerning self		
					administration and storage of medication. Resident #8 is in		
	F: 1: . 1	1			agreement and was re-assessed	hv	
	Findings include:				the Wellness and deemed capat	-	
					safe storage and self administration		
	The clinical re	ecord for Resident #8			of medication utilizing the		
		on 4/5/11 at 1:00			medication self administration		
					assessment. Resident #8's physi		
		ord indicated Resident			was in agreement and an order v	was	
	# 8 had chronic low back pain related to degenerative arthritis. The physician orders, dated				obtained for resident to keep medications in apartment and se	olf.	
					administer.	211	
					ddiffinster.		
	1 * *	·			How the facility will identify o	ther	
		ated "Oxycontin [pain			residents having the potential		
	medication] 4	0 mg [one] BID [two			affected by the same deficient		
	times daily]."				practice and what corrective		
					action will be taken? No other residents were found to	. 1	
	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \				affected.	o be	
	1	on of missing of			arrected.		
	medications, of	lated 3/19/11, no			What measures will be put into	0	
	time, indicated	d "3/19/11 Received			place or what systemic change		
	call from (dau	ghter name)			will the facility make to ensure		
	,	r mother's (Resident			that the deficient practice does	s not	
	1	`			recur? The Wellness Director was		
	1	edications. She stated			re-educated to our policy and		
	that her mothe	er's Oxycontin [a			procedure regarding self		
	narcotic] had	been replaced by what			administration of medication.		
	_	blood pressure pill.			Residents who self administer w		
					re-assessed by the Wellness Dire	ector	
		later in the day,			and re-educated to our policy	1	
	approx [appro	ximately] 4:00 pm			concerning self administration a		
	and said that a	ifter checking her			storage of medication. Resident found to be incapable of self	5	
		other medications that			administration and storage of		
	she had discov				medication will have the family	and	
	sile flau discov	vereu mai nei			physician notified and the		

004376

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUI	(X2) MULTIPLE CONSTRUCTION A. BUILDING O		(X3) DATE SURVEY COMPLETED 04/06/2011	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE	04/00/2011
SHIELDS	HOUSE			SEYMO	DUR, IN47274	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	a diabetes pill Aspirin. I mad meet with her 3/20/11 at 4:00 (Resident # 8's her mother (Rewas given a bothat contained unknown pill identified as Minterviewed (F said that she kin a basket in laide (CNA # 1 her cart on Fricher. She stated the same thing The daughter state the count mothers (sic) I thought the phinistake on the The policy and Resident Medinal Record, dated "If the reside "If the res	Resident # 8) and she ept her medications her walker. That an 2 name) had taken day to clean it up for I that she had done about a month ago. Said that she noticed was off on her ast month, but armacy had made a			medications administered by the Residence with the service plan updated to reflect the provision provided by staff. How will the corrective action will be monitored to ensure the deficient practice will not receive, what quality assurance program will be put into place. The Wellness Director or Designate will perform an ongoing assess of residents who self administed medications to ensure continue compliance no less than quartee. Findings will be reviewed and corrected through our QA process. By what date will the systemic changes be completed? Compliance Date: May 15, 20	n ss s s s s s s s s s s s s s s s s s

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE COMPI 04/06/2	LETED		
	PROVIDER OR SUPPLIEI	 	STREET ADDRESS, CITY, STATE, ZIP CODE 2288 NICHOLAS CT SEYMOUR, IN47274				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
	which staff do AND the apar cabinet must be In an interview Nurse on 04/0 he indicated " medications] s	n a locking box (to be not have a key) the the three kept locked" w with the Regional 16/11 at 10:00 A.M., They [the should have been in a trin her [Resident #8]					